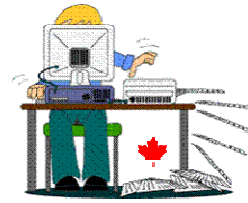


## Media Watch...

is distributed weekly to my colleagues who are active or have a special interest in **hospice, palliative care** and **end-of-life issues** – to help keep them abreast of current, emerging and related issues, and to also inform discussion and to encourage further inquiry.

1 March 2010 Edition | Issue #138



Compilation of Media Watch 2008, 2009, 2010 ©

Compiled & Annotated by Barry R. Ashpole

**Aggressive treatment at the end of life: Scroll down to [U.S.A.](#) and 'Murky path in deciding on care at the end' published in the *New York Times* (p.5).**

## Canada

### Population trends

#### **Not enough support for aging population: Report**

CANWEST NEWS SERVICE | Online report – Accessed 1 March 2010 – The federal government has been both a leader and a laggard in grappling with the challenges of Canada's rapidly aging population, according to the chair of the Senate Special Committee on Aging [Senator Sharon Carstairs]. The committee's final report ... finds "serious gaps" in the health care, housing, transportation and support systems available to the ever-increasing ranks of seniors. Support for caregivers is insufficient, the committee found, and many Canadians are forced to choose between keeping their jobs and caring for loved ones. <http://www.leaderpost.com/health/diet-fitness/Body+mass+waist+size+predict+heart+disease/2316636/enough+support+aging+population+Report/1522799/story.html>

Of related interest:

- CBC | Online report – 23 February 2010 – **'Life expectancy in Canada nears 81.'** Newborn Canadians may live to celebrate nearly 81 birthdays on average, a Statistics Canada report on life expectancy suggests.<sup>1</sup> <http://www.cbc.ca/health/story/2010/02/23/life-expectancy-canada.html>
- U.K. | *The Economist* – 18 February 2010 – **'No place like home: A political row overshadows the interests of the elderly.'** In Britain the government reckons that half of all men and two-thirds of women will require support in their declining years including, in many cases, residential care. [http://www.economist.com/world/britain/displayStory.cfm?story\\_id=15549192&source=hptextfeature](http://www.economist.com/world/britain/displayStory.cfm?story_id=15549192&source=hptextfeature)
- WORLDWIDE PALLIATIVE CARE ALLIANCE | Press release – 13 February 2010 – **'Worldwide Palliative Care Alliance calls for urgent action to support aging population.'** As populations age, the pattern of diseases that people suffer and die from also changes, with more people affected by chronic diseases such as heart disease, cancer, respiratory disease and dementia – in turn increasing the demand for palliative care services. <http://www.thewpca.org/latest-news/aging-population/>

## 'Big, big gap' in care hurts terminally ill

ONTARIO | *Ottawa Citizen* – 25 February 2010 – A growing number of terminally ill Eastern Ontarians are spending their final days in hospital, waiting for specialized palliative care when most of them could be treated in their own homes, hospices or nursing homes, says the physician leading a redesign of the care people here get at the ends of their lives. That blockage is contributing to a shortage of hospital beds for patients, which in turn causes cancelled surgeries and long waits in emergency rooms, said Dr. José Pereira, medical chief of palliative care services at Bruyère Continuing Care and The Ottawa Hospital. Pereira, a renowned expert who helped design regional palliative-care services in Alberta, said Eastern Ontario needs more services that allow people to spend their final days in more humane and less costly settings, such as hospices and nursing homes. And more family doctors need to be trained to provide their patients with the basics of palliative care so the burden is taken off the handful of specialists who currently do the bulk of the work, said Pereira. At the moment, seven out of 10 terminally ill patients at the Queensway Carleton Hospital die there while waiting for beds at Bruyère's 36-bed palliative-care unit. <http://www.ottawacitizen.com/health/care+hurts+terminally/2609157/story.html>

- ONTARIO | *Ottawa Citizen* (Letter) – 27 February 2010 – **'We need more care for dying patients.'** Dr. José Pereria's message must get the attention from health administrators and politicians it merits. I am surprised there are only 35 hospice beds in our area. Even raising that number to 88 ... seems woefully inadequate, given the aging population. <http://www.ottawacitizen.com/health/need+more+care+dying+patients/2620608/story.html>

Of related interest:

- ONTARIO | *Chatham Daily News* – 25 February 2010 – **'CCAC launches palliative team.'** A new program aimed at decreasing hospital admissions and emergency department visits was launched in Chatham-Kent. The Erie St. Clair Community Care Access Centre's palliative care consultation team also hopes to prevent hospital readmissions and enhance specialized palliative care in the home. <http://www.chathamdailynews.ca/ArticleDisplay.aspx?e=2466927>

### Specialist Publications

Of particular interest:

**'The stress process in palliative cancer care: A qualitative study on informal caregiving and its implication for the delivery of care.'** Scroll down to p.8 for the findings of a Canadian study published in *American Journal of Hospice & Palliative Medicine*.

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ONTARIO | *Kingston Whig Standard* (OpEd) – 27 February 2010 – **'Terminal illness: hanging on or letting go?'** Reading the obituaries in the newspapers, I discover two contrasting ways that people with terminal illnesses confront the process of dying. Some die "after a courageous and often prolonged struggle." Others die "peacefully" (and often quickly) having accepted their demise graciously. These two ways of responding or reacting to the personal end times, I call "letting go" and "hanging on." <http://www.thewhig.com/ArticleDisplay.aspx?e=2469554>
- CBC NEWS | Online report – 26 February 2010 – **'B.C. woman fights for right to die.'** A 94-year-old Victoria woman is making no secret of her wish to commit suicide, but she can't find anyone to give her the lethal medication she needs to end her life. <http://www.cbc.ca/canada/british-columbia/story/2010/02/26/bc-bernice-packford-right-to-die.html>

## U.S.A.

### Family Health Care Decisions Act

#### Who speaks for those who can't?

NEW YORK | *Times Union* – 25 February 2010 – The [State] Senate approved the Family Health Care Decisions Act by an overwhelming bipartisan vote. The bill would allow family and friends to be involved in health care decisions for loved ones who are determined by a physician to be incapacitated. Currently, state ... law forbids the withdrawal of life support without the presence of "clear and convincing evidence," such as a health care proxy, do-not-resuscitate order or living will. "Unfortunately, only about 20 percent of people in our state sign health care proxies," said [Democrat] Senator Tom Duane Manhattan, the bill's sponsor. "This legislation will protect those people who are unable to make decisions for themselves, if they're in a hospital or in a nursing home." <http://www.timesunion.com/AspStories/story.asp?storyID=904551&category=STATE>

- MSNBC-TV | Online report – 26 February 2010 – **'Living wills often ignored.'** Living wills and advance directives were the hope for end-of-life decision-making decades ago. [http://www.msnbc.msn.com/id/35610499/ns/health-health\\_care/](http://www.msnbc.msn.com/id/35610499/ns/health-health_care/)

### Hospice and the economy

#### Hospital cutting some services to save money

SOUTH CAROLINA | *Times & Democrat* (Orangeburg) – 25 February 2010 – The Regional Medical Center will phase out its outpatient hospice program over the next 45 days in an effort to cut costs and focus on other operations. The hospital's outpatient hospice program, which includes about 80% of its hospice services, employs between 12 and 15. The program has operated at annual losses of about \$300,000 to \$500,000 for the past several years. The hospital will continue to provide its inpatient hospice, Home Health and Palliative Care programs. <http://www.thetandd.com/articles/2010/02/25/news/doc4b86024405b7e691178736.txt>

From Media Watch dated 22 February 2010:

- *KAISER HEALTH NEWS* | Online OpEd – 18 February 2010 – **'Why are fewer patients enrolling in hospice?'** Suddenly, many hospices are admitting fewer patients. Cash-strapped hospices are cutting back on nurses and aides, and patients are missing out on critical end-of-life care. <http://www.kaiserhealthnews.org/Columns/2010/February/021810Gleckman.aspx>

Of related interest:

- NEW JERSEY | *North Jersey* – 28 February 2010 – **'End-of-life care: Can we afford it?'** An abbreviated version of 'The economics, ethics, and financial issues of end-of-life care: Do third party payers distort end-of-care decisions?' presented by Murray Sabrin, Professor of Finance, Anisfield School of Business, Ramapo College, at the recent Eastern Economics Association conference. [http://www.northjersey.com/news/opinions/End\\_of\\_life\\_care\\_can\\_we\\_afford\\_it.html](http://www.northjersey.com/news/opinions/End_of_life_care_can_we_afford_it.html)

### Health reform: End of life care

#### An American cry for help

MSNBC-TV | Countdown – 24 February 2010 – Anchor Keith Olbermann shares his personal experience with a real life 'death panel' situation and scorns the unfairness of health insurance in America. [http://www.msnbc.msn.com/id/35566903/ns/msnbc\\_tv-countdown\\_with\\_keith\\_olbermann](http://www.msnbc.msn.com/id/35566903/ns/msnbc_tv-countdown_with_keith_olbermann)

## Artificial nutrition and hydration

### **Bishops cite 'obligation' for using feeding tubes at religious facilities**

*KAISER HEALTH NEWS* | Online report – 24 February 2010 – An elderly woman taken last year to St. John Medical Center in Tulsa, Oklahoma, had suffered a massive stroke and could no longer speak, eat or drink. Although she had an advance directive specifying no artificial hydration or nutrition if she weren't going to recover, local health officials said, her nephew insisted the local bishop's directive on use of feeding tubes required the Catholic hospital to install one. Her doctors and St. John officials debated how to proceed, struggling with ethically charged issues that hundreds of Catholic hospitals and nursing homes could face under new doctrine. It states in part that Catholic health facilities have "an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally." If a patient – or family – didn't want a feeding tube "and the reason they don't want it is they basically want to die, then the Catholic institution would explain to them they can't cooperate with that and they would have to go to another institution," said the Rev. Thomas G. Weinandy, executive director for doctrine at the bishops' conference, who helped draft the policy.  
<http://www.kaiserhealthnews.org/Stories/2010/February/24/Catholic-directive-may-thwart-end-of-life-wishes.aspx>

From Media Watch dated 22 February 2010:

- *JOURNAL OF PARENTERAL & ENTERAL NUTRITION*, 2010;34(1):79-88. **'Ethical issues in artificial nutrition and hydration: A review.'** The intent of this review is to supply a framework of clinical practices, ethical principles, legal precedents, and professional guidelines that will impart information and can assist decision making regarding artificial nutrition and hydration.  
<http://pen.sagepub.com/cgi/content/abstract/34/1/79>

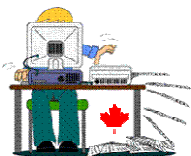
## Pain and symptom management

### **Are doctors too reluctant to prescribe opioids?**

*TIME MAGAZINE* | Online report – 24 February 2010 – Although opioids are extremely valuable painkillers, particularly for patients at the end of life, drugs like ... oxycodone and ... hydrocodone and acetaminophen ... are unfortunately better known for being addictive. While new studies have sharpened the understanding of how opioids work, and clarified their harms, the general question of safety remains complicated. <http://www.time.com/time/health/article/0,8599,1964782,00.html>

### **Health workers' conscience rights proposal moves forward**

*IDAHO REPORTER* | Online report – 22 February 2010 – A Senate committee has approved the proposal extending the freedom of conscience to pharmacists and other health care workers in circumstances involving emergency contraception and end of life care. Hospitals and hospital employees currently have such conscience rights. <http://www.idahoreporter.com/2010/health-workers-conscience-rights-proposal-moves-forward/>



### **Barry R. Ashpole**

My involvement in palliative and end-of-life care dates from 1985. As a communications specialist, I've been involved in or responsible for a broad range of initiatives at the community, regional, provincial and national level. My work focuses primarily on advocacy, capacity building and policy development in addressing issues specific to those living with a life-threatening or terminal illness – both patients and families. In recent years, I've applied my experience and knowledge to education, developing and teaching on-line and in-class courses, and facilitating issue specific workshops, for frontline care providers.

## Murky path in deciding on care at the end

*NEW YORK TIMES* | Online article – 22 February 2010 – Aggressive treatment at the end of life – frantic CPR [cardiopulmonary resuscitation] for a brain-dead accident victim, inserting a feeding tube in a dying Alzheimer's patient – has become a staple of the health care debate. Critics argue that vast resources are squandered on care that is obviously futile. But in a recent issue of *The New England Journal of Medicine*, personal essays by two doctors make it clear that when it comes to real-world medicine, the situation is far from clear-cut.<sup>1,2</sup> There may be situations when futile care can be appropriate, one doctor says. And the other writes that all the rational decision-making and evidence-based medicine so popular today can vanish in an instant when emotions come into play – when the patient with dementia is not an anonymous old woman but your own grandmother. <http://www.nytimes.com/2010/02/23/health/23life.html>

1. *NEW ENGLAND JOURNAL OF MEDICINE*, 2010;362(6):477-479. **'Is it always wrong to perform futile CPR?'** Although there is currently much debate about the types of care to which patients are entitled, one thing on which everyone can agree is that non-beneficial care should be eliminated. [http://content.nejm.org/cgi/content/extract/362/6/477\\_N.B.](http://content.nejm.org/cgi/content/extract/362/6/477_N.B.)

**N.B.** Noted in Media Watch dated 15 February 2010.

2. *NEW ENGLAND JOURNAL OF MEDICINE*, 2010;362(6):479-481. **'Failing to thrive.'** My mother and I were on vacation in New York when we got a call from my aunt and uncle, both psychiatrists, in Portland, Oregon. My 90-year-old, demented paternal grandmother seemed to be having a stroke. They wanted to know whether they should take her to the emergency room. <http://content.nejm.org/cgi/content/extract/362/6/479>

Of related interest:

- PENNSYLVANIA | *Philadelphia Inquirer* – 28 February 2010 – **'A look at the new field of palliative care.'** Ten years ago, palliative care teams were just beginning to form in a few American hospitals. This year, the 12-person team at Abington [Memorial Hospital] will hold 1,200 meetings with families like Mary Tole's. Palliative care is medicine's response to the dismal way people have died. One purpose is to help patients and families make hard decisions when facing chronic illness. [http://www.philly.com/inquirer/front\\_page/20100228\\_A\\_look\\_at\\_the\\_new\\_field\\_of\\_palliative\\_care.html](http://www.philly.com/inquirer/front_page/20100228_A_look_at_the_new_field_of_palliative_care.html)

## When disease can't be cured

OREGON | *Mail-Tribune* – 21 February 2010 – Palliative care already is an important part of hospice care for dying patients, but it also can be appropriate for people who need help to manage the symptoms of cancer, congestive heart failure and other diseases that eventually will be fatal. <http://www.mailtribune.com/apps/pbcs.dll/article?AID=/20100221/NEWS/2210325>

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *ATLANTIC* | Online article – March 2010 – **'Death becomes him.'** Over the past decade, Ludwig Minelli has helped more than 1,000 people kill themselves and has turned Zurich into the undisputed world capital of assisted suicide. <http://www.theatlantic.com/doc/201003/dignitas-assisted-suicide>
- MASSACHUSETTS | My Stateline – 22 February 2010 – **'Right To Die Bill to be considered in Massachusetts.'** A ... legislative committee will consider a bill ... that would legalize euthanasia for the terminally ill. If legalized, the Massachusetts would become the fourth state with such a law after Montana, Oregon and Washington. <http://mystateline.com/content/fulltext/?cid=139482>

## International

### Department of Health puts end-of-life care spending question to Strategic Health Authorities

U.K. | Community Care – 26 February 2010 – The ... decision to quiz strategic health authorities on exactly how they are spending £286 million earmarked for end-of-life care has been criticised by hospice experts. A ... letter to all strategic health authorities and primary care trusts asks them to identify the services that have received additional investment from the funding. The cash was to support the government's End of Life Care Strategy, but was not ringfenced [i.e., may only be used for a previously specified purpose]. Jonathan Ellis, director of public policy at Help the Hospices, said: "A real concern is that this huge investment has been made without any clear monitoring or accountability." <http://www.communitycare.co.uk/Articles/2010/02/26/113916/dh-puts-end-of-life-care-spending-question-to-shas.htm>

Of related interest:

- U.K. | *Times* – 1 March 2010 – '**Terminally ill unable to die at home through lack of nursing cover.**' More than a third of family doctors are not reviewing the needs and wishes of dying patients, while round-the-clock nursing care is not available to give patients support and pain relief at weekends and at night in many areas. [http://www.timesonline.co.uk/tol/life\\_and\\_style/health/article7044550.ece](http://www.timesonline.co.uk/tol/life_and_style/health/article7044550.ece)

### "It's terminal": How to break bad news

U.K. | *The Independent* – 23 February 2010 – It's an important part of a doctor's job to give patients the worst news they're ever likely to hear. Why do so many still get it so wrong?

**Article's opening paragraph:** "You have cancer. It's terminal." My father, who died last month, was so distraught upon hearing these words that my mother never felt able to ask him whether he thought the consultant's bluntness was inappropriate. Nor did she ask my father whether he considered it bad practice that he was told at 9 p.m., immediately after which my mother was asked to go home because "visiting hours are over." Or whether my father found it tactless that, when he asked the consultant whether there was anything they could do for him, he was told irritably it was too late in the evening to discuss.

**Article's closing paragraph:** When it became clear that my father was rapidly going downhill, I tapped the arm of a consultant doing the ward rounds to ask for an update. Despite the consultant being rushed off his feet and bound by patient confidentiality (my father never wanted anyone to know how ill he was), he took a pragmatic approach, taking me into the relatives' room and explaining that he felt it was important that someone in my family was informed he had days, possibly hours, left. He sat with me while I cried and answered every question I had truthfully and sensitively. It's hard to quantify exactly how his respectfulness and kindness helped, but there's no doubt in my mind that it did.

#### Specialist Publications

Of particular interest:

**'Provider communication and patient understanding of life-limiting illness and their relationship to patient communication of treatment preferences.'**

Scroll down to p.10 for the findings of a randomized controlled trial published in the *Journal of Pain & Symptom Management*.

**'Direct communication, the unquestionable ideal? Oncologists' accounts of communication of bleak prognoses.'**

Scroll down to p.10 for the findings of focus group interviews published in *Psycho-Oncology*.

Link to *The Independent* article: <http://www.independent.co.uk/life-style/health-and-families/features/its-terminal-how-to-break-bad-news-1907316.html>

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. (SCOTLAND) | *Press & Journal* – 27 February 2010 – **'Scrutiny of assisted suicide bill to begin.'** Members [of a committee of the Scottish Parliament] will scrutinise the merits of introducing new legislation [End of Life Assistance (Scotland) Bill] at the behest of independent MSP [Member of the Scottish Parliament] Margo MacDonald, who suffers from Parkinson's disease.  
<http://www.pressandjournal.co.uk/Article.aspx/1624421?UseRKey=>
- AUSTRIAN | *Independent* – 25 February 2010 – **'Strong support for legal euthanasia.'** Most Austrians think euthanasia in the final stage of a lethal disease should go unpunished, a poll has shown.  
[http://austrianindependent.com/news/General\\_News/2010-02-24/1199/Strong\\_support\\_for\\_legal\\_euthanasia](http://austrianindependent.com/news/General_News/2010-02-24/1199/Strong_support_for_legal_euthanasia)
- U.K. | BBC News – 25 February 2010 – **'Motivation key over assisted death prosecutions.'** New guidelines over whether people would face prosecution over assisting suicide place closer scrutiny on a suspect's motivation.  
<http://news.bbc.co.uk/2/hi/health/8536231.stm>  
  
**N.B.** The "public interest factors" the Director of Public Prosecutions would consider in favour of or against prosecution:  
[http://www.cps.gov.uk/news/press\\_releases/109\\_10/](http://www.cps.gov.uk/news/press_releases/109_10/)
- U.K. | *Daily Telegraph* – 24 February 2010 – **'Debbie Purdy criticises Gordon Brown over assisted suicide.'** 'Right-to-die' campaigner Debbie Purdy criticised Gordon Brown for showing a "lack of respect" to the British people after the Prime Minister warned against legalising assisted suicide.  
<http://www.telegraph.co.uk/news/newstopics/politics/lawandorder/7304653/Debbie-Purdy-criticises-Gordon-Brown-over-assisted-suicide.html>
- U.K. | *Daily Telegraph* – 23 February 2010 – **'Gordon Brown: don't legalise assisted suicide.'** [Prime Minister] Gordon Brown has warned against legalising assisted suicide as prosecutors prepare to introduce guidelines that will make it easier to help others end their lives without ... punishment.  
<http://www.telegraph.co.uk/news/newstopics/politics/lawandorder/7301399/Gordon-Brown-dont-legalise-assisted-suicide.html>
- U.K. | *The Argus* (Brighton) – 22 February 2010 – **'Assisted suicide should be allowed...'** Terminally ill and elderly patients suffering unbearable pain should be allowed to commit suicide with the help of their doctor. A poll of the city's residents found the overwhelming majority agreed in assisted suicide, where terminally ill patients were expected to die in less than six months.  
[http://www.theargus.co.uk/news/5019987.Assisted\\_suicide\\_should\\_be\\_allowed\\_says\\_Brighton/](http://www.theargus.co.uk/news/5019987.Assisted_suicide_should_be_allowed_says_Brighton/)

### [Media Watch Online](#)

The weekly report can be accessed at several websites, among them:

#### **Canada**

Ontario | Hamilton  
Niagara Haldimand Brant  
Hospice Palliative Care  
Network:

<http://www.hnhbhpc.net/Resources/UsefulLinks/MediaWatch/tabid/97/Default.aspx>

Ontario | HPC  
Consultation Services:  
<http://www.hpcconnectio.n.ca/newsletter/inthenews.html>

#### **U.S.A.**

*Prison Terminal:*  
<http://www.prisonterminal.com/news%20media%20watch.html>

#### **International**

Global | Palliative Care  
Network Community:  
<http://www.pcn-e.com/community/>

U.K. | Omega, the  
National Association for  
End of Life Care:  
<http://www.omega.uk.net/media-watch-provides-global-roundup-of-end-of-life-issues-n-96.htm>

## Specialist Publications (e.g., in-print and online journal articles, reports, etc.)

### **The stress process in palliative cancer care: A qualitative study on informal caregiving and its implication for the delivery of care**

*AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE*, 2010;27(2):111-116. The primary stressors associated with caring for the palliative cancer care patients stemmed from care recipient symptoms and personal care needs [according to the findings of the authors' face-to-face interviews with bereaved family caregivers]. The absence of adequate support from the formal health care delivery system was a consistent message from all participants. There was evidence of financial stress primarily associated with the purchase of private home care to supplement formal care. In contrast, the resources that family caregivers relied on to moderate the stressful effects of caregiving included extended family, friends, and neighbors. While the stress of direct caregiving was high ... formal care was also a significant source of stress for family caregivers.  
<http://ajh.sagepub.com/cgi/content/abstract/27/2/111>

From Media Watch dated 02.15.10.

- UNIVERSITÉ LAVAL (FACULTY OF SOCIAL SCIENCES) | Press release – 10 February 2010 – **'Keeping end-of-life patients at home comes at a high cost to families.'** Keeping end-of-life patients at home comes at a high cost to families, according to a Canada-wide study. <http://www.newswire.ca/en/releases/archive/February2010/10/c8428.html>
- 1. *PALLIATIVE MEDICINE*, 2009;23(8): 708-717. **'Costs associated with resource utilization during the palliative phase of care.'** This study aimed to evaluate prospectively the resource utilization and related costs during the palliative phase of care in five regions across Canada.  
<http://pmj.sagepub.com/cgi/content/abstract/0269216309346546v1>

### Media Watch: Editorial Practice

Each listing in Media Watch represents a condensed version or extract of what is broadcast, posted (on the Internet) or published; in the case of a journal article, an edited version of the abstract or introductory paragraph, or an extract. Headlines are as in the original article, report, etc. There is no editorializing ... and, every attempt is made to present a balanced, representative sample of "current thinking" on any given issue or topic. The weekly report is issue-oriented and offered as a potential advocacy tool or change document.

### Distribution

Media Watch is distributed at no cost to colleagues active or with a special interest in hospice, palliative care and end of life issues. Recipients are encouraged to share the weekly report with *their* colleagues. The distribution list is a proprietary one, used exclusively for the distribution of the weekly report and occasional supplements. It is not used or made available for any other purpose whatsoever – to protect the privacy of recipients and also to avoid generating undue e-mail traffic.

### Links to Sources

1. Links are checked and confirmed as active before each edition of Media Watch is distributed.
2. Links often remain active, however, for only a limited period of time.
3. Access to a complete article, in some cases, may require a subscription or one-time charge.
4. If a link appears broken or inactive, try copying/pasting the URL into the address bar of your browser or, alternatively, Google the title of the article or report, and the name of the source.
5. Due to its relevance, an article may be listed but for which a link is not available; access, therefore, may only be possible directly from the source (e.g., publication) or through the services of a library.

### Something Missed or Overlooked?

If you are aware of a current report, article, etc., relevant to hospice, palliative care or end-of-life issues not mentioned, please alert this office (contact information below) so that it can be included in a future issue of Media Watch. Thank you.

## Life review in critical care: Possibilities at the end of life

*CRITICAL CARE NURSE*, 2010;30:17-27. Beardslee & Vaillant claim that "at some point in life, there are suddenly more yesterdays than tomorrows."<sup>1</sup> This claim is certainly true for dying patients in critical care who have lost the ability to fulfill the roles and responsibilities of life. Profound listening work offers the chance to recapture a patient's personhood. Most likely, this recapturing occurs via the stories of loved ones, for as Kiernan stated, "we convey meaning through stories."<sup>2</sup> Health care professionals have a definitive opportunity to foster a good death, to promote the completion of final developmental tasks. Such is the essence of life review.  
<http://ccn.aacnjournals.org/cgi/reprint/30/1/17>

1. Beardslee WR, Vaillant G. 'Adult development.' In: Tasman A, Kay J, Lieberman JA, eds. *Psychiatry*. 2nd ed. Hoboken, NJ: John Wiley & Sons Inc; 2003:145-155.
2. Kiernan S. 'Now more than ever: the growing need for change in end-of-life.' Paper presented at the Florida Hospices & Palliative Care Annual Conference; March 13, 2009; Orlando, FL.

### "More" often means "less"

#### First home death leaves impression

*DOCTOR* (New Zealand) | Online column – 24 February 2010 – In the community, you may experience sudden death through violence, accident or self harm, or the expected death of someone frail or chronically ill, perhaps after months of palliative care. Even with the chronically ill it is unusual to be present as someone dies, but in the last days, if it is possible, spend some time sitting in the room, holding the patient's hand, watching the friends and relatives as they placate each other with stories and jokes, join with them in reminiscences, share some food. Careful appreciation of how people are feeling and how this affects their behaviour is needed: relatives often want something more to be done to make their loved one's death quicker and easier. Intervention is tempting, but, in palliative care, "more" often means "less," and explanation about why a catheter is not needed, or a drip not required, prevents iatrogenic complications. Time spent embracing relationships is never wasted. Those of us who have lost involvement with intrapartum care regret not being there at a significant life point more than anything else. It is not only good for your grieving to take advantage of this privilege; everyone in the room remembers how "the doctor was there for them," a comforting thought when contemplating their own demise.  
<http://www.nzdoctor.co.nz/news?article=962a788c-bb0b-476f-9fe5-29ee5a76fe10>

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE*, 2010;13(3):331-332. **'The power of presence.'** When I think of the power of presence, I realize that it is not given the honor it deserves. People think they have to do more. They think they have to somehow fix it or make it better or they have not offered anything of value. <http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2009.0313>

#### **End-of-life discussions, goal attainment, and distress at the end of life: Predictors and outcomes of receipt of care consistent with preferences**

*JOURNAL OF CLINICAL ONCOLOGY*, 2010;28(7):1203-1208. The authors sought to evaluate factors that help patients to receive care consistent with their preferences. Overall, 68% of patients [i.e., study participants] received EOL care consistent with baseline preferences. The proportion was slightly higher among patients who recognized they were terminally ill. Patients who recognized their terminal illness were more likely to prefer symptom-directed care. However, some patients who were aware they were terminally ill wished to receive life-extending care.  
<http://jco.ascopubs.org/cgi/content/abstract/28/7/1203>

## **Provider communication and patient understanding of life-limiting illness and their relationship to patient communication of treatment preferences**

*JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 22 February 2010 – Medical decision making in the context of serious illness ideally involves a patient who understands his or her condition and prognosis and can effectively formulate and communicate his or her care preferences. To understand the relationships among these care processes, the authors analyzed baseline interview data from veterans enrolled in a randomized controlled trial of a palliative care intervention. Patients who believed that they had a life-limiting illness reported that their provider had communicated this to them more frequently than those who did not share that belief. Over half of the participants reported discussing their care preferences with their providers and 66% reported such discussions with their family; 35% had a living will. Patients with poor understanding of prognosis are less likely to discuss care preferences with family members, suggesting the importance of provider communication with patients regarding prognosis. [http://www.jpmsjournal.com/article/S0885-3924\(10\)00073-4/abstract](http://www.jpmsjournal.com/article/S0885-3924(10)00073-4/abstract)

Of related interest:

- *PSYCHO-ONCOLOGY* | Online article – 23 February 2010 – '**Direct communication, the unquestionable ideal? Oncologists' accounts of communication of bleak prognoses.**' Primarily focusing on open communication regarding bleak prospects of life expectancy entails a risk of overrunning the information needs of individual patients. Oncologists still see communication skills primarily as personal, and are at risk of not exploring and responding to the individual patient's wish for information. <http://www3.interscience.wiley.com/journal/123290537/abstract>

## **Recognizing that it is part and parcel of what they do: Teaching palliative care to medical students in the U.K.**

*PALLIATIVE MEDICINE* | Online article – 22 February 2010 – The General Medical Council in the United Kingdom has given clear recommendations that all medical students should receive core teaching on relieving pain and distress together with caring for the terminally ill. However, medical schools provide variable amounts of this teaching; some are able to deliver comprehensive programmes whilst others deliver very little. This paper presents the results of a mixed methods study which explored the structure and content of palliative care teaching in different U.K. medical schools, and revealed what coordinators are trying to achieve with this teaching. Nationally, coordinators are aiming to help medical students overcome the same fears held by the lay public about death, dying and hospices, to convey that the palliative care approach is applicable to many patients and is part of every doctor's role, whatever their specialty. Although facts and knowledge were thought to be important, coordinators were more concerned with attitudes and helping individuals with the transition from medical student to foundation doctor, providing an awareness of palliative medicine as a specialty and how to access it for their future patients. <http://pmj.sagepub.com/cgi/content/abstract/0269216309356029v1>

## **Assisted (or facilitated) death**

Representative sample of recent articles, etc:

- *BRITISH MEDICAL JOURNAL* | Online report – 26 February 2010 – '**Doctors face greater risk of prosecution than the public for assisting suicide.**' Doctors face a greater risk of prosecution if they assist a patient to commit suicide than do the individual's family members or friends, under final guidelines on assisting a suicide in England and Wales issued by the director of public prosecutions. [http://www.bmj.com/cgi/content/extract/340/feb26\\_1/c1167](http://www.bmj.com/cgi/content/extract/340/feb26_1/c1167)
- *SUPPORTIVE CARE IN CANCER*, 2010;18(3):359-366. '**Attitudes toward assisted death amongst Portuguese oncologists.**' Portuguese oncologists are mainly against the practise of euthanasia and assisted suicide and the number of requests is also relatively low. <http://springerlink.com/content/y001671311118646/?p=95ad4c82a22d4cb5878147c0ebc91597&pi=10>

## Worth Repeating

### **Spiritual issues in the care of dying patients**

*JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, 2006;296(11):1385-1392. Spiritual issues arise frequently in the care of dying patients, yet health care professionals may not recognize them, may not believe they have a duty to address these issues, and may not understand how best to respond to their patients' spiritual needs. The case of a patient with a strong religious belief in a miraculous cure of metastatic pancreatic cancer is used to explore how better understanding of this belief and more explicitly spiritual conversation with the patient by his treating team might have provided opportunities for an improved plan of care. This article distinguishes spirituality from religion; describes the salient spiritual needs of patients at the end of life as encompassing questions of meaning, value, and relationship; delineates the role physicians ought to play in ascertaining and responding to those needs; and discusses the particular issue of miracles, arguing that expectations of miraculous cure ought not preclude referral to hospice care. Link to complete article: <http://nurseweb.ucsf.edu/public/shobe/pdfs/5-sulmasy.pdf>

#### Quotable Quotes

*Spirituality is about one's relationship with the transcendent questions that confront one as a human being and how one relates to these questions. A religion, by contrast, is a set of texts, practices, and beliefs about the transcendent, shared by a particular community. Spirituality, in this respect, is broader than religion. While not everyone has a religion, spiritual issues, in this wider sense, arise for almost all dying persons.*

**Daniel P. Sulmasy**, author of  
'Spiritual issues in the care of  
dying patients'

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